

Organizational and Leadership Ethics

Maine Primary Care Association
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Michael A. Gillette, Ph.D.
(434)384-5322 mgillette@bsvinc.com
<http://www.bsvinc.com>

Introduction to Ethical Process

MEDICAL ETHICS CASE STUDY

THE CASE OF MS. G

4 YEARS OLD

PRESENTS WITH MOTHER/LEGAL GUARDIAN

THREE DAYS STATUS POST GREENSTICK
FRACTURE TO THE RIGHT RADIUS, BONES ARE
UNDISPLACED.

BACKGROUND INFORMATION

- THE FOREARM WAS PREVIOUSLY PLACED IN A FIBERGLASS CAST WHICH IS NOW WET
- THE MOTHER INITIALLY REQUESTED THAT THE CAST BE REMOVED BECAUSE IT GOT WET
- THE PHYSICIAN INDICATED THAT THE CAST WAS IN GOOD CONDITION AND COULD BE DRIED WITHOUT FIRST BEING REMOVED
- THE MOTHER THEN DEMANDED THAT THE CAST BE REMOVED AS SHE DESIRED TO TREAT THE FRACTURE WITH HERBAL REMEDIES INCLUDING HOT COMPRESSES
- A BRIEF ORTHOPEDIC CONSULT RESULTED IN THE OPINION THAT THE CAST SHOULD REMAIN IN PLACE



Two Standard Approaches (Theory)

Ethical Theory

NORMATIVE ETHICS

- Utilitarianism (J.S. Mill): Always act so as to bring about the greatest good (happiness) for the greatest number.
- Deontology (Immanuel Kant): Always treat people as ends in themselves, never as a means only.
- Virtue Theory (Aristotle): Always act consistently with the standards of the role you play in life.

CORE VALUES

“Principles of Medical Ethics”

Autonomy

Nonmaleficence

Beneficence

Justice

An Alternate Approach (Casuistry)

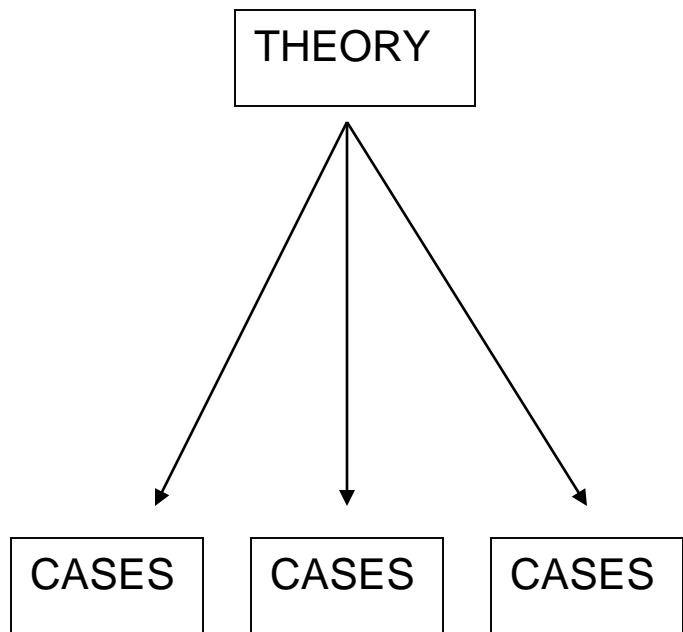
The Eye Doctor
or
Reverse Engineering

Methods of Doing Ethics

“Theory and Casuistry”

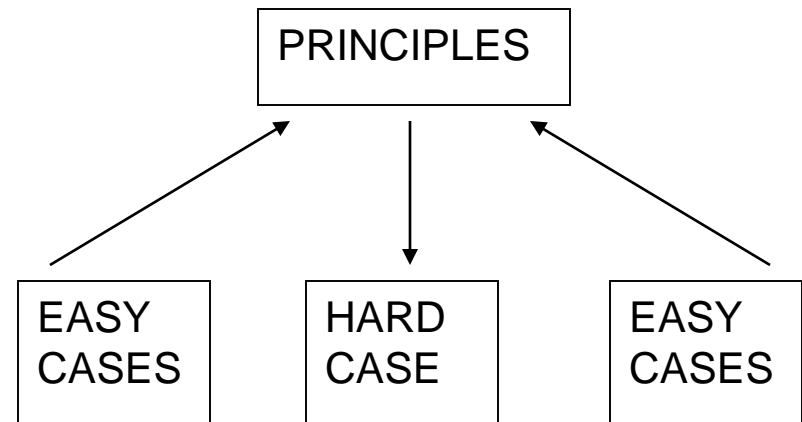
Theory

Top-Down



Casuistry

Bottom-Middle-Down



Casuietry takes place in a three dimensional conceptual space involving multiple data points and is not restricted to two analogues.

We become wiser as we get older because our bank of experience is broader.

Think about Pong vs. a modern video game. As resolution improves, detail becomes visible.

The Structure of a Pragmatic Argument

A Procedural Approach To Ethics

The Five R's

REVIEW the situation and identify the problem/area of need

RESPOND to the issues

REDUCE the list of possible responses

RECAST the conflict

RESOLVE the dispute and clarify the confusion



The Five R's

A Procedural Approach To Ethics

- 1) **Review** the situation, identify the problem, define the area of need:

This stage requires the gathering of information. Become familiar with the present situation and identify the factors that might be relevant.

a) Are there any genuine problems here? Do I perceive the possibility of confusion or disagreement? Are any “normal” procedures being ignored? What motivates concern in this case?

b) Is this problem medical, social, legal, or moral? Do I have the resources needed to solve the problem? Who/what are my additional resources?



The Five R's

A Procedural Approach To Ethics

2) **Respond** to the issues:

List all possible responses to the situation. Identify all of the arguments that could be made in support of each possible response. Responses can either be an intuitive or answers that you believe to be obviously incorrect. Either way, your initial responses and arguments will be only starting points for further development, or targets for criticism.

The Five R's

A Procedural Approach To Ethics

3) **Reduce** the list of possible responses:

Eliminate excess arguments either by combining redundant views, ignoring irrelevant views, or eliminating irrational views. Even positions that appear correct should be subjected to criticism. Why would anyone respond in the ways listed in step two? Develop supporting positions and create counter-examples to all positions. Examine difficult ramifications of accepting possible views.

The Five R's

A Procedural Approach To Ethics

4) **Recast** the conflict:

Once the central arguments and options for response have been identified and considered, recast the issue in order to clarify the operative concepts. Appeal to analogues that admit to clearer intuitions in order to place the present issue in a clear conceptual framework.

The Five R's

A Procedural Approach To Ethics

5) **Resolve** the dispute and clarify the confusion:

Once the issues have been identified, and analogous cases have been considered, identify acceptable responses to the issue and develop an action plan for implementing recommendations. If possible, construct a generalizable theory that accounts for the acceptable options and explain how exceptions might be accommodated without giving up on the ethical principles involved. Once this has been accomplished, create a universalizable view that will help in other cases. Show why your final position is not unique to the case at hand, or alternatively, show how this case is in fact morally unique.

IDENTIFY THE BURDEN OF PROOF



The Structure of Ethical Argument

The Process of Moral Reasoning

The Default Assumption

The Burden of Proof

Casuistic Exploration

Application to the Current Case

Back to the Example

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THE ARGUMENTS

- PARENTAL AUTHORITY
- PHYSICIAN AUTHORITY
- BEST INTEREST OF THE CHILD (PATIENT)
- BEST INTEREST OF THE FAMILY
- LEGAL AND POLICY ISSUES



THE STRATEGY

- LEGAL/POLICY ISSUES: [INCONCLUSIVE]
APPROPRIATELY, THESE GIVE INSUFFICIENT GUIDANCE
- BEST INTEREST OF THE FAMILY: [IRRELEVANT]
THE WELFARE OF THE FAMILY (NON-PATIENTS) IS OF
SECONDARY OR INDIRECT CONCERN ONLY
- BEST INTEREST OF CHILD (PATIENT): [DIVERGENT EVALUATIONS]
ALL PARTIES INVOLVED HAVE AN OBLIGATION TO SECURE
WHAT IS IN THE CHILD'S BEST INTEREST
- PARENTAL VS. PHYSICIAN AUTHORITY:
WHOSE JUDGEMENT SHOULD PREVAIL IN THIS CASE?

Family Authority

Parental authority over minor children is powerful, *but not absolute* :

- The burden of proof rests with those seeking to overrule parental authority.
- Parental authority does not empower a parent to be negligent in the care of a child.
- Parental authority does not empower a parent to be abusive in the care of a child.
- Parental authority does not empower a parent to demand that care providers offer sub-standard care.

Three Responses to Conflict Between Providers and Families

1. If it can not be shown that the family's choice is abusive, negligent, or inconsistent with the standard of care, the care must be provided.
2. If it can be shown that the family's choice is inconsistent with the standard of care, but not abusive or negligent, then care can be refused but transfer must be allowed.
3. If it can be shown that the family's choice is abusive or negligent, judicial relief is appropriate.

EXAMINATION OF THE CONFLICT

QUESTIONS:

- IS THERE A CLEAR MEDICAL INDICATION?
- WOULD FAILURE TO CAST THE ARM BE NEGLIGENT OR ABUSIVE?
- ARE THERE ANY OTHER OPTIONS THAT ARE LESS INVASIVE OF THE FAMILY'S VALUES?

ASSUMPTIONS:

- FAMILY AUTHORITY REMAINS INTACT UNLESS THE PARENT IS ACTING NEGLIGENTLY OR ABUSIVELY TOWARD THE CHILD
- THE BURDEN OF PROOF RESTS WITH THOSE WHO WOULD INTERVENE AND USURP PARENTAL AUTHORITY



CONCLUSION

- UNLESS THE PHYSICIAN CAN CONFIDENTLY SUPPORT THE VIEW THAT THE FAMILY IS ACTING NEGLIGENTLY OR ABUSIVELY IN THIS CASE, SHE MUST RECOGNIZE AND ACCEPT PARENTAL AUTHORITY
- IF THE PHYSICIAN FEELS THE FAMILY'S CHOSEN COURSE OF ACTION IS NOT ABUSIVE OR NEGLIGENT BUT IS INCONSISTENT WITH THE STANDARD OF PRACTICE, SHE MAY REMOVE HERSELF FROM THIS CASE
- A COMPROMISE OPTION OF SPLINTING AND FOLLOW-UP OFFICE VISITS SATISFIES ALL CONCERNS



Casuistry In Action

The Ethics of Refusing Treatment

“Listen To Me Or Else...”

Ms. I was recently assigned a new physician to the practice who advised her that she needed to lose 20 pounds and quit smoking. The physician repeated the same recommendations on two subsequent office visits, but after 18 months Ms. I has neither lost weight nor quit smoking. Her physician recently called for an ethics consult to determine if he could discharge her from his practice for noncompliance.



The Ethics of Refusing Treatment

“Cocaine or Coumadin”

Mr. J is a 61-year-old individual who receives services from PACE which include the provision of Coumadin for treatment of a cardiac blood clot. Mr. J suffers from CHF, COPD, Renal insufficiency, Hypertension, Chronic Thrombosis and he is S/P CVA. Mr. J's most serious risk factor presently is his admitted continued use of crack cocaine. Mr. J lives in his own apartment, although he is currently at risk of eviction, and receives in-home ADL and medication management support from PACE. Staff has become increasingly uncomfortable with continuing to provide Mr. J with Coumadin given his ongoing use of crack cocaine which counteracts the clinical efficacy of warfarin, but ethical question has emerged regarding the withdrawal of Coumadin from an individual with a known thrombosis.

The Ethics of Refusing Treatment

“Infection By Injection”

Ms. K is a 20-year-old recurrent patient at the local hospital who has been hospitalized on an almost monthly basis for IV antibiotic therapy of a recurring infective endocarditis. After receiving antibiotic therapy, the bacterial infection generally resolves. However, providers believe that Ms. K’s IV drug abuse is the source of the recurrent infections. Ms. K refuses to stop using heroin and on her most recent hospitalization she is suspected of having introduced illicit drugs by means of her IV line. She developed a new infection in the hospital which staff believe was introduced by injection of less than sterile substances.



Leadership Ethics and Moral Management

Ethics in Supervision

Ethics in Supervision

“When Can I Squeal?”

As a member of the Senior Management Team, you are aware that budgetary limitations are likely to require reductions in staffing on certain units. You have been asked to keep this information confidential, because the specific decisions as to how the cuts will be made have not yet been finalized. One of your direct supervisees is in the process of buying a new home and has expressed his excitement at finally having a stable enough job to make home ownership possible. Should you warn the employee of the upcoming cuts and recommend that he wait on buying the house until after his position is secure?



Moral Management

“Being Nice Vs. Being Ethical”

Supererogation



Moral Management

“Identify the Default Assumptions”

Background Obligations



Moral Management

“The Source of Obligation”

What Is Your Role?



Moral Management

“The Source of Obligation II”

What Are Your Relationships?



Moral Management

“How Relationships Work”

Tacit Expectations

Explicit Promises

Moral Management

“What Ethical Leaders Do”

- Identify Default Obligations
- Recognize Distinct Obligations Across Individuals, Disciplines and Departments
- Prioritize Conflicting Obligations
- Support Valid Processes

Roles and Boundaries

Information Control

“I’m Not Asking Much”

Mr. D provides services at a local residential SA program and often transports individuals in the agency van from one location to another. During one such drive, Mr. D was struck by a motorcycle after turning onto a street. Although Mr. D believes that he stopped at the corner first, and then carefully entered the intersection where he was hit by the motorcycle that was traveling too quickly, he has been charged with failure to yield. Mr. D believes that the van passengers can help in his defense, but is unsure whether or not he may submit their names to his attorney or the court so they might be called as witnesses.



Information Control Revisited

Boundaries and Dual Relationships

The previous case is not fundamentally about confidentiality and the control of information. The core ethical issue is one of boundaries and dual relationships. The nature of the relationship between the provider and the recipient determines the appropriate ethical response.

Additional Cases

Dual Relationships

“The Greatest Gift”

Facility Director A recently learned that the Nursing Director in her agency wants to have a child, although she underwent an hysterectomy several years ago. The Nursing Director’s ovaries were not impacted by the surgery and she is looking for a contract parent who will carry her eggs after they are fertilized by her husband’s sperm in-vitro. The Facility Director has indicated a desire to help by serving as the contract mother.

Dual Relationships

“I Can Help You Out”

Ms. L is a 19-year-old unmarried college student who has been receiving pre-natal care from a local OB. Toward the end of her pregnancy, Ms. L indicates that she really doesn't think that she can care for her baby, but she is unsure what to do. The OB is supportive and understanding. She explains to Ms. L that he and his wife have wanted to have a baby for quite some time and that they would be happy to provide a good home to Ms. L's child.

Ethics in Adolescent Psychology

“Foster Care”

A mental health counselor working at a residential center has identified two children in his care that need foster care placement. The counselor has indicated a desire to provide those services directly and has begun foster care provider training. Should these children be placed with the mental health counselor as foster children?

Basic Concepts

Dual Relationships

The Definition

Dual relationships may be defined as situations in which individuals simultaneously maintain a professional (or agency related) relationship and a conflicting outside relationship. A professional (or agency related) relationship and an outside relationship shall be considered to conflict whenever the following two conditions exist: (1) one person plays the role of provider or supervisor of services to the other person that involves access to information about or the exertion of control over the provision of services; (2) the individuals are involved in a hierarchical, dependent or influential relationship that is not part of the professional relationship.



Dual Relationships

The Dangers

Dual Relationships are dangerous because they:

- Create the opportunity for the erosion of objectivity on the part of service providers
- Create pressure on patients to act in accordance with staff wishes (loss of patient autonomy). This loss of patient freedom may be the result of intentional manipulation or unintentional influence
- Create the opportunity for secondary gain on the part of staff, and thus create real or apparent conflicts of interest
- Create situations in which the authority of care providers may be eroded
- Create opportunities for the loss of confidentiality
- Support the development of double standards (other patients lose trust, other patients' care deteriorates)



Dual Relationships

Some Questions To Ask

1. Is the consumer voluntarily engaged in this activity?
2. Is this activity consistent with my role as a care/service provider?
3. Is this activity available equally to all the capable consumers whom I serve?
4. Do I experience secondary gain by engaging in this activity?
5. Does the facility experience secondary gain by engaging in this activity?
6. Is there significant opportunity for this activity to negatively impact on my ability to do my job?
7. Is there a reasonable chance that the consumer(s) involved in this activity may misconstrue the nature of our relationship as a result of the activity?
8. Is this activity something that I would rather other staff and consumers not know about even in general terms?
9. Is this activity a reasonable part of the consumer's treatment/service plan?
10. Have I spoken about this activity with my supervisor?



The Allocation of Scarce Resources: A Review

Allocation Ethics

Wait Until He Ages Out

Mr. Z is a 19-year-old individual with ID who has been receiving specialized services through the school system in his locality. Mr. Z has decided that he does not want to go to school anymore and his family has been looking for appropriate assistance in the community. They have requested services from the CSB but funding is scarce. Mr. Z requires intensive supports and the CSB has determined that it would prefer to use its resources for individuals who have no other options. Is it ethical to refuse to provide services to Mr. Z because he is eligible for school-based support until he is 22?



The Ethics of Scarcity

“Serve More Or Serve Better?”

Both Mr. H and Ms. I will do very well with therapy A, but that therapy is so intensive, that staff can only provide it to one client at a time. Both Mr. H and Ms. I will do marginally well with therapy B and that service could be provided to both simultaneously. Is it preferable to maximize outcomes to one individual at a time or secure marginal improvement for multiple individuals simultaneously?

The Ethics of Scarcity

“Who Is First?”

Ms. K and Ms. L are both under consideration for placement in your vocational program. Ms. K has many more challenges than Ms. L and is less likely, therefore, to succeed with long term job placement. While Ms. L is more likely to move through the program efficiently, she has a more substantial family support system and can do better without your support. Should Ms. K or Ms. L receive the next available slot in the program?

Ethical Challenges

“No Alternatives By Choice”

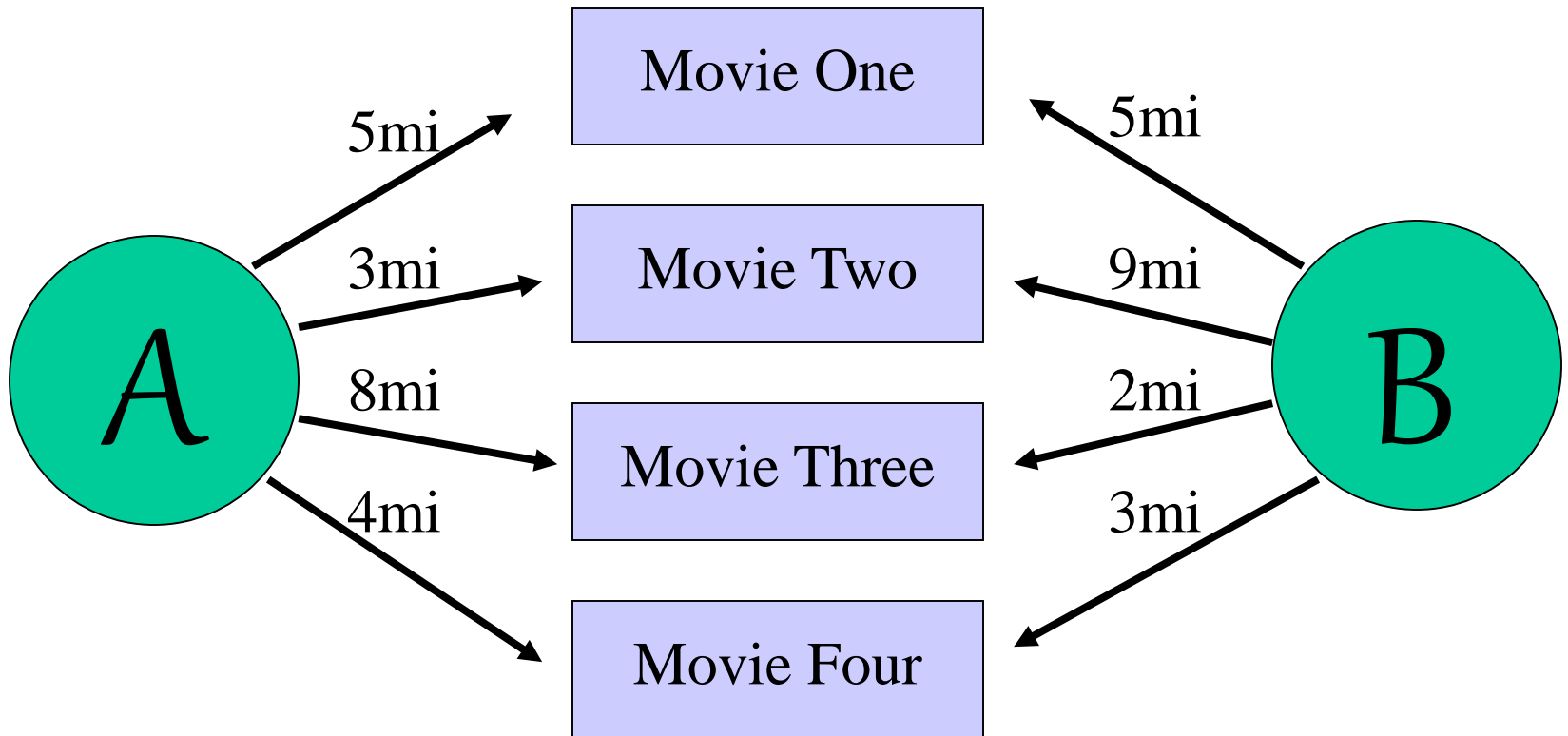
Ms. E is a CSB client who recently refused to complete the application process to participate in Medicare Part D. Ms. E indicates that she does not want to go through the effort of completing the paper work and choosing a plan, and that she would prefer just to work with the agency to utilize their medication samples to receive free medications. Staff believe that Ms. E would meet eligibility for Medicare Part D and wonder if they can refuse to provide low-cost or no-cost medications given Ms. E’s other alternatives.



Some Basic Concepts

The Allocation of Resources

The Concept of Fairness



The Ethics of Scarcity

“The Four E’s”

1. Efficiency: A maximally efficient outcome is one that provides the highest ratio of output over input in a system. Efficiency does not consider the distribution of outcomes across recipients, but only the return on investment that is generated.
2. Effectiveness: A maximally effective outcome is one that maximizes benefit to the recipient of the resources or services in question so as to bring about the greatest gain for the chosen recipient. When we consider effectiveness, we apply the economic principle of maximax; obtaining the best possible best-case outcome.
3. Equality: An equal distribution is one that maximizes the degree of similarity of outcome for all recipients of goods or services.
4. Equity: A maximally equitable distribution of goods or services is that which minimizes harm to the non-recipient of resources or services in question so as to bring about the least harm to the least advantaged recipients. When we consider equity, we apply the economic principle of maximin; obtaining the best possible worst-case outcome.

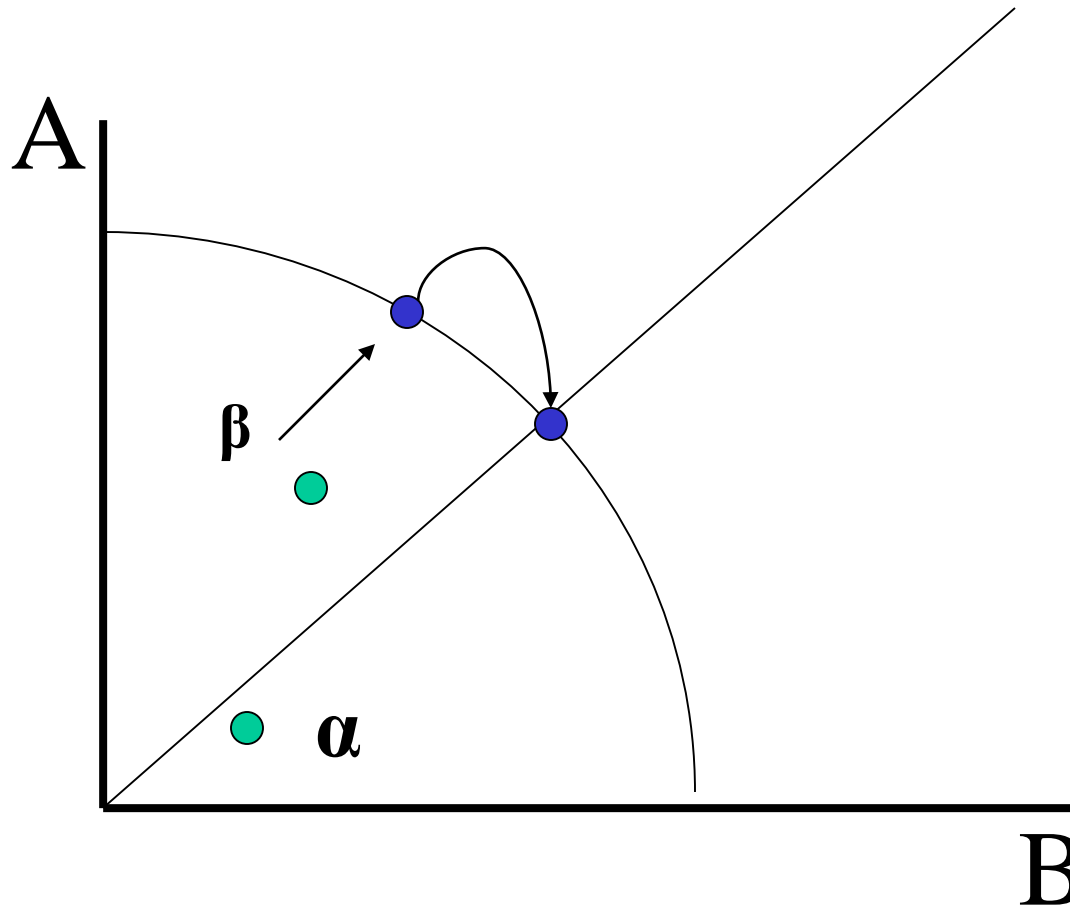
The Allocation of Resources

Effectiveness, Efficiency, Equality, Equity

	α	β	γ	δ
A	1000	950	-7	500
B	25	100	-5	300

The Allocation of Resources

The Concept of Fairness



Allocation Ethics

“The Process of Rationing”

1. A fair approach to rationing is one that seeks to maximize benefit to the least advantaged member of the group.
2. Once minimum standards are met for everyone, additional resources should be used to improve the situation of those who are least advantaged

Allocation Ethics

“The Justification of Rationing”

Rationing a PUBLIC resource is morally justified if and only if:

1. There actually exists a shortage of the resource in question,

AND

2. An identifiable victim of a failure to ration exists,

AND

3. The victim of the adopted rationing scheme is disadvantaged less than the victim of any other rationing scheme, including the lack of rationing altogether.

The Ethics of Scarcity

“Altered Standards of Care”

In an environment of true scarcity, our goal must be to minimize the harms done rather than to maximize the benefits received.

When allocating scarce resources, our only constraint on the lower end is to satisfy minimum standards of care.



Operational Guidelines: Micro-Allocation

The Ethics of Scarcity

“Exclusionary Criteria”

Constituency: The facility exists as an agency within a specific geographic and political location that is designed to meet the needs of individuals who reside in that area. While it may be appropriate to enter into cooperative regional efforts with neighbors and thereby extend constituency claims in specific ways, services should otherwise be restricted to those individuals who are residents of the catchment area.

Inappropriate Requests: Some individuals may request services that the facility is simply not designed, mandated or funded to satisfy. We recommend that the organization must clearly define what it does, and that it is ethical to refuse to provide services that are inconsistent with its mission.



The Ethics of Scarcity

“Inclusionary Criteria”

Prior Commitment: Currently enrolled individuals who continue actively to satisfy the terms of their treatment plans should remain enrolled even if new potential consumers present with equal or greater need. We do not believe that active clients should have their services withdrawn for so long as the services that have been initiated are indicated.



The Ethics of Scarcity “Inclusionary Criteria”

Alternative Resources (Need, Part I): If the organization is defined as a safety net provider, then this designation implies that the facility has a special obligation to help individuals who *need* to be helped. Individuals who can access services by other means do not actually need our services. Therefore, we recommend that such individuals may ethically be considered as lower priority in the face of scarcity and may be excluded from further consideration

The Ethics of Scarcity

“Inclusionary Criteria”

Need (Part II): We recommend that those individuals with serious and imminent needs should be given priority over those with lesser need. Need must be understood to include the risk of harm associated with a failure to access services. When assessing need, all efforts should be made to identify those individuals who will suffer serious and imminent risk to life or irreversible harm. Clearly, many individuals will present with a variety of needs. At this point in the process, however we consider only those individuals whose need is of a serious, emergent type such that failure to meet their needs will likely result in A) loss of basic physiological function, B) exposure to life and/or safety risks, C) failure to meet basic developmental needs, or D) degeneration of condition that will lead to one of risks A-C. These individuals should be given priority at this step in the allocation process.



The Ethics of Scarcity

“Inclusionary Criteria”

Efficiency: Once those with serious and imminent needs have been served, assuming that additional resources remain for allocation, the organization should attempt to serve as many individuals as possible. Therefore, efficiency now becomes a relevant factor. The organization should, at this point, rank possible allocation schemes in order to maximize efficiency. Efficiency should be understood to include not only serving the maximum number of individuals, but also a cost-benefit analysis. If revenues can be generated by serving some clients, those new revenues can then be used to extend the scope of service. These types of efficiency calculations are morally acceptable after we have served those already in the system and those with serious and imminent risks



The Ethics of Scarcity

“Inclusionary Criteria”

Effectiveness: Once we have maximized efficiency, if resources continue to be available, priority may then be placed on individuals who show the greatest likelihood of maximally benefiting from receipt of services. While the concept of efficiency is applied across a group of individuals, the concept of effectiveness is applied to specific individuals and indicates a desire to maximize the outcome for the targeted individuals.

The Ethics of Scarcity

“Inclusionary Criteria”

Comparative Need: Once basic needs have been met and efficiency and effectiveness achieved, attention may then shift to a comparative analysis of lesser needs. At this point in the allocation process, individuals should be rank ordered based upon the likelihood that we can support their achievement of better social functioning, higher cognitive development and employment success. Needs of these types should be distinguished from the more serious and imminent needs addressed above, although we in no way mean to indicate that this level of need is unimportant.

The Ethics of Scarcity

“Inclusionary Criteria”

Random Selection: Once the above delineated criteria have been applied, it is plausible to argue that any remaining claims on services are of relatively equal urgency and efficiency. Recognition of this fact generates an assumption that all additional claims are of equal value and should be treated equally. It is then ethically permissible to allocate any remaining resources on the basis of random selection. We recommend that a first-come-first served selection model is ethically acceptable at this point.



A Summary

The Ethics of Scarcity “Exclusionary Criteria”

Constituency

Inappropriate Requests

The Ethics of Scarcity “Inclusionary Criteria”

Prior Commitment

Serious Need: Imminent Risk and No Alternatives

Efficiency

Effectiveness

Comparative Need

Random Selection

Autonomy, Gender, Sex and Sexuality

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Michael A. Gillette, Ph.D.
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Autonomy, Paternalism, and Distributive Justice

The Ethics of Patient Refusal

“There’s Nothing Wrong With Me”

Mr. L is a 60-year-old patient who carries a diagnosis of schizophrenia, NOS with fixed delusions. He has been hospitalized on a number of occasions for treatment of infections associated with a large mass on his right thigh that is suspected to be squamous cell carcinoma. Mr. L has no insight into his illness and refuses surgical intervention to remove the mass. He believes that he can treat the growth with topical salves and nicotine. Given the extent of tumor growth, the surgical intervention being contemplated is an above the knee amputation, but the surgeon is reticent to provide surgery over the patient’s objections. An ethics consult was requested to determine whether or not court authorization for treatment over the patient's objections should be obtained.

Individual Choice

Basic Assumptions

1) What is the default assumption regarding an adult individual's right to direct his/her own healthcare?

2) Where does the burden of proof rest? Does the patient have to justify control, or do those who would intervene have to justify wresting control away from the individual?

3) What would it take to satisfy the burden of proof?

Individual Choice

The Burden of Proof

- 1) All other things being equal, individuals have an autonomy right to control their own care.
- 2) The burden of proof rests on the party that would restrict an individual's autonomy right.
- 3) The burden of proof can be satisfied on the basis of only two classes of argument: prevention of harm to self (paternalism) and prevention of harm to others (distributive justice).

Paternalism

An intervention is ‘paternalistic’ whenever the justification for the restriction of an individual’s freedom is calculated to be in their own best interest.

Distributive Justice

An intervention is justice-based whenever the justification for the restriction of an individual's freedom is that it is calculated to protect a victim of the individual's action other than him/herself.



The Two
Paradigms Explained:
Harm To Self

Ethics in Long-Term Care

“Psychiatric Instability”

Mr. C is a resident in assisted living who has requested to return to independent living. Staff indicate that Mr. C was admitted to assisted living based on concern surrounding his documented suicidal ideation and a desire to closely monitor his medication management, even though he did not meet UAI criteria for assisted living. It is unclear how Mr. C scores on the UAI currently but his physical function has not deteriorated since admission. However, Mr. C does have a history of depression and there is some concern that we will be less able to monitor his mental health status in independent living. The primary ethical issue is based, therefore, on whether or not depression, without associated losses of physical function, creates a legitimate basis for ruling out an individual for living independently.

Requirements For Paternalism

Paternalistic interferences with clients' liberty of action are justified only when:

- The client lacks the capacity for autonomous choice regarding the relevant issue
- There is a clearly demonstrated clinical indication for the treatment or restriction under consideration
- The treatment or restriction under consideration is the least restrictive alternative that is reasonably available and capable of meeting the client's needs
- The benefits of the treatment under consideration outweigh the harms of the interference itself

Paternalistic interventions must attempt to advance the values of the individual whose freedom is restricted.



Diminished Capacity

Basic Assumptions

The two most important things to remember at the beginning of any interaction with a patient surrounding capacity issues are:

1) All adults should be presumed to have capacity until they are explicitly found to lack it,

2) An individual cannot be found to lack capacity simply because s/he carries a particular clinical diagnosis.

Diminished Capacity

The Definition of Capacity

In order for a patient to have diminished capacity, s/he must meet at least one of three criteria:

- 1) The inability to understand information about the decision that needs to be made (ARBs)
- 2) The inability to use the information, even if understood, to make a rational evaluation of the risks and benefits involved in the decision
- 3) The inability to communicate by any means

Diminished Capacity

Incapacity Determinations

There is an important difference between a clinical finding of incapacity that can be documented by the attending physician, and a legal adjudication of incompetence.

A determination that a patient has diminished capacity can apply to a particular healthcare decision, a set of healthcare decisions, or all healthcare decisions.

It is essential that a clinician making a determination that a patient has diminished capacity be able to define the scope of the finding and its basis. A note must be set forth in writing to indicate something like “This patient is unable to make decisions of type X because of deficit Y.”

Diminished Capacity

Important Concepts

- Capacity is task specific, so incapacity must be assessed relative to the particular decisions at hand.
- Patients can maintain capacity in certain decisional areas while simultaneously lacking it in others.
- The amount of capacity necessary to make any particular decision is relative to the complexity of the decision and the risks associated with the decision. Therefore, clinicians should be very careful when assessing the inability of patients to make complicated high-risk choices and to verify that the patient lacks a sufficient level of capacity to take responsibility for those choices.

The Two
Paradigms Explained:
Harm To Others

Ethics and Dementia

“The Silver Fox”

Mr. S is an 82-year-old gentleman who presented in his primary care physician's office requesting that his Foley Catheter be removed. When asked why he wanted the Foley removed, Mr. S replied that he "wanted to have sex". The attending believes that Mr. S could tolerate the removal of his catheter for a short period of time, and agrees that Mr. S has the right to engage in a sexual encounter if he desires to do so.

The attending asks Mr. S with whom he intends to have sex and Mr. S replies that "there are any number of women on the third floor who would be happy to oblige". The attending knows that Mr. S is correct in his assumption, but she also knows that the third floor of the nursing home where Mr. S resides is the Alzheimer's unit. Many of the women on that unit are married, but don't remember that information. Furthermore, they are women who would not have consented to a casual sexual relationship prior to onset of their illness, but they have lost many of their inhibitions secondary to their dementia.



Requirements For Justice

Justice-based interferences with clients' liberty of action are justified only when:

- The client behaves in some manner that places others at risk
and
- Those placed at risk have not provided valid consent to be placed at risk (either by choice or incapacity)
and either
- The risk of harm to others is more significant than the harm generated by restricting the client's freedom and is not protected by an identified right (deterrence)
or
- The client forfeits his/her right to liberty by transgressing a clearly defined social expectation (punishment)

Some Recent Cases

The Ethics of Forced Treatment

“But The Attending Insists”

Mr. M is an 86-year-old patient who was admitted to the hospital for an acute exacerbation of his COPD. It was determined that he was hyperkalemic but Mr. M refused aggressive management. He and his family requested a return home to where the patient was already admitted to hospice. Mr. M's attending in the hospital believes that she can reverse the high potassium and she told the patient that leaving the hospital without treatment was not possible. Mr. M then insisted on leaving but the attending told him that she would hold him over his objections. Mr. M then grabbed the cord on a lamp in his room and threatened that if he were not allowed to leave, that he would kill himself by strangling himself with the cord. When a nurse approached Mr. M, he grabbed a pencil and threatened to “stick her with it”. A psychiatric evaluation was requested and the mental health evaluator indicated in her note that Mr. M does not suffer from any mental illness, that his suicidal statements do not represent any true suicidal ideation, and that he does not pose a threat of harm to self or others secondary to a mental illness. The note went on to say that although Mr. M did not appear to meet criteria for detention, she would certify the TDO because “the attending insists”. An ethics consult was then requested by nursing staff.



The Ethics At The End Of Life

“Are We Finishing The Act?”

Mr. K is a 27-year-old patient who was brought into the hospital secondary to an overdose that was a clear suicide attempt. After several days in the hospital it has become clear that Mr. K has suffered severe and irreversible anoxic brain injury. The family has determined that Mr. K would not want to live in a PVS and that continued treatment is not in his best interest. They have requested that Mr. K be extubated and allowed to die. Staff are uncomfortable with this request, however, because they feel that they will be contributing to a successful suicide. Should the fact that Mr. K's condition was caused by a suicide attempt impact the current decision regarding the withdrawal of life prolonging care?



The Ethics of Patient Refusal

“This Isn’t A La Carte”

Mr. O is a 92-year-old patient in renal failure who refuses dialysis. He had received dialysis for several years and currently has capacity to make his own healthcare decisions. However, concurrently with his refusal of dialysis, Mr. O insists on remaining a full code. Staff do not know how to manage these seemingly contradictory demands.

The Ethics of Information Control

“He Doesn’t Need To Know”

Mr. J is an 81-year-old patient who was admitted to the oncology unit and was determined to have pancreatic cancer. Mr. J’s son carries durable power of attorney for healthcare and he ordered that his father be placed on comfort care, without the patient’s knowledge. Mr. J is alert and oriented most of the time, although he does become somewhat disoriented in the evening when he is tired.

Gender, Sex, and Sexuality

Issues For Discussion

Information and Documentation

Gender: Placement and Services

Staff Discomfort

An Opening Case

Sex and Gender

“Is It Clinically Relevant?”

Mr. Z presented in the emergency department where it was determined that he would need to have a catheter inserted. Mr. Z was a rugged looking man with a full beard. When the nurse prepared to insert the catheter, she realized that Mr. Z is a transgender individual with female genitalia. The nurse quickly adjusted to the situation in order to catheterize the patient properly. An issue then arose because Mr. Z insisted that he be listed on the chart as a man and that he did not want “transgender” to be inserted into the record. The attending believed that Mr. Z’s biological sex could be clinically relevant to future treatment decisions, but he was unsure if he should chart Mr. Z’s transgender status over his objections.

Definitions

From The World Health Organization

What do we mean by "sex" and "gender"?

Sometimes it is hard to understand exactly what is meant by the term "gender", and how it differs from the closely related term "sex".

"Sex" refers to the biological and physiological characteristics that define men and women.

"Gender" refers to the socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women.

"Male" and "female" are sex categories, while "masculine" and "feminine" are gender categories.

Aspects of sex will not vary substantially between different human societies, while aspects of gender may vary greatly.



From The World Health Organization

Some examples of sex characteristics:

Women menstruate while men do not

Men have testicles while women do not

Women have developed breasts that are usually capable of lactating, while men have not

Men generally have more massive bones than women

Some examples of gender characteristics:

In the United States (and most other countries), women earn significantly less money than men for similar work

In Viet Nam, many more men than women smoke, as female smoking has not traditionally been considered appropriate

In Saudi Arabia men are allowed to drive cars while women are not

In most of the world, women do more housework than men



The National Center For Transgender Equality

Transgender:

A term for people whose gender identity, expression or behavior is different from those typically associated with their assigned sex at birth.

Transgender is a broad term and is good for non-transgender people to use. “Trans” is shorthand for “transgender.” (Note: Transgender is correctly used as an adjective, not a noun, thus “transgender people” is appropriate but “transgenders” is often viewed as disrespectful.)



Additional Definitions

Cis-sexual or Cis-gender:

A term for people whose gender identity and sexual preferences match the gender and sexual identity that they were assigned at birth.

The National Center For Transgender Equality

Gender Identity:

An individual's internal sense of being male, female, or something else. Since gender identity is internal, one's gender identity is not necessarily visible to others.

Gender Expression:

How a person represents or expresses one's gender identity to others, often through behavior, clothing, hairstyles, voice or body characteristics.



The National Center For Transgender Equality

Transsexual:

An older term for people whose gender identity is different from their assigned sex at birth who seeks to transition from male to female or female to male. Many do not prefer this term because it is thought to sound overly clinical.



The National Center For Transgender Equality

Queer:

A term used to refer to lesbian, gay, bisexual and, often also transgender, people. Some use queer as an alternative to “gay” in an effort to be more inclusive. Depending on the user, the term has either a derogatory or an affirming connotation, as many have sought to reclaim the term that was once widely used in a negative way.

Genderqueer:

A term used by some individuals who identify as neither entirely male nor entirely female.

Gender Non-conforming: A term for individuals whose gender expression is different from societal expectations related to gender.



The National Center For Transgender Equality

Intersex:

A term used for people who are born with a reproductive or sexual anatomy and/or chromosome pattern that does not seem to fit typical definitions of male or female. Intersex conditions are also known as differences of sex development (DSD).



Additional Definitions

Sexual Orientation

heterosexual (cis-sexual)

homosexual (gay, lesbian)

bisexual

pan-sexual

a-sexual



Example Cases

Ethical Issues in Mental Health

“Gender Placement”

The consult was initiated in response to a placement issue for a consumer, Ms. V, who is currently undergoing gender reassignment. Although the consumer has been receiving hormones for some time and presents outwardly as a woman, Ms. V still has male genitalia. In preparation for leaving an in-patient setting, Ms. V requested to be placed in a residential facility that houses only woman. The operators of that facility felt that the other residents had a right to know that Ms. V is still a man, and asked Ms. V to disclose her status to the other residents. Ms. V refused to disclose her biological sex, however, and an ethics consult was requested to determine whether or not the residential facility could make disclosure a condition for admission.

The Ethics of Gender

“Transgender Placement”

Client J is physically male but is in the process of gender affirmation therapy. The client is appropriate for job placement services and wants to be presented to potential employers as a female. The counselor is uncomfortable with this request and refuses to refer to the client in the feminine.

The Ethics of Gender

“Who Makes the Decision?”

F.L. is a 14-year-old client who has a long history of sexually acting out, including having sex with zir younger sister when they were both at a very young age. Mx. L was removed from the home along with zir sister, and it is suspected that zie was sexually victimized by an older boy who lived in zir group foster placement. Mx. L then lived in a congregant living setting but was transferred to zir current setting, which specializes in children and adolescents with sexual issues, approximately one year ago. Mx. L was placed in the male side of the facility until zie reported zir transgender status approximately one month ago. Mx. L was then moved to the female side of the facility without notification or consent from the legal guardian – the Department of Family Services. Staff has raised question about the appropriateness of this move given the fact that documentation made as recently as two weeks ago indicates no resolution or therapeutic progress regarding sexual predation on females and no history of danger or discomfort had been noted regarding the prior living arrangements. In both the male and female dormitories, Mx. L had been provided with a private room, and in all cases access to the bathrooms is allowed only one person at a time. This ethics case consultation was requested to address any ethical issues that exist in making housing placement decisions for Mx. L without the guardian’s input.



The Ethics of Gender

“An Adolescent”

Ms. L is a 15-year-old transgender female student at a residential mental health facility whose parents do not accept her gender status. Ms. L does carry a diagnosis of borderline personality disorder but she insists that her six-month history of expressing her female gender is genuine. Staff are unsure whether she should be housed in the male or female dormitory.

The Ethics of Gender

“Is This Authentic?”

Mr. M is a 28-year-old group home resident who carries a diagnosis of Factitious Disorder, PTSD, Borderline Personality Disorder and Bipolar Affective Disorder. Mr. M has a history of symptoms significant of factitious disorder, including previous episodes of claiming progressive deafness and blindness, both of which resolved once staff ruled the patient out for those problems and it became clear that clinical intervention was not going to be initiated to remedy the reported concerns. Approximately six months ago, Mr. M, who is biologically female, declared that he was a transgender individual and that he now wants to undergo hormonal therapy in preparation for gender affirmation surgery. Mr. M will not consent to a release of his medical records from the CSB to consulting specialists, but he demands that staff actively assist him in his sexual reassignment efforts. Staff members are unsure about how actively they must support a clinical effort about which they have doubts and with regard to which they are restricted from discussing clinical details with outside providers.



The Ethics of Gender

“Medicaid Will Pay”

Client K is physically female but is in the process of gender reassignment therapy and is living in the male gender role. Mr. K is appropriate for participation in group therapy, but the only group in the area that is offered by a Medicaid accepting organization is for women only. Mr. K wants the therapy, and he demands that since he is biologically female that he be allowed to attend.

A Recent Legal Opinion

UNITED STATES
COURT OF APPEALS

FOR THE FOURTH CIRCUIT

No. 15-2056

G. G., by his next friend and mother,
Deirdre Grimm, Plaintiff - Appellant,

v.

GLOUCESTER COUNTY SCHOOL BOARD,
Defendant - Appellee.

The Gavin Grimm Case

The Argument From Ambiguity

Although the regulation may refer unambiguously to males and females, it is silent as to how a school should determine whether a transgender individual is a male or female for the purpose of access to sex-segregated restrooms. We conclude that the regulation is susceptible to more than one plausible reading because it permits both the Board's reading—determining maleness or femaleness with reference exclusively to genitalia—and the Department's interpretation—determining maleness or femaleness with reference to gender identity.



The Gavin Grimm Case

The Argument From Ambiguity

It is not clear to us how the regulation would apply in a number of situations—even under the Board’s own “biological gender” formulation. For example, which restroom would a transgender individual who had undergone sex-reassignment surgery use? What about an intersex individual? What about an individual born with X-X-Y sex chromosomes? What about an individual who lost external genitalia in an accident? The Department’s interpretation resolves ambiguity by providing that in the case of a transgender individual using a sex-segregated facility, the individual’s sex as male or female is to be generally determined by reference to the student’s gender identity.



The Gavin Grimm Case

The Argument From Ambiguity

We disagree with the dissent’s suggestion that the result we reach today renders the enforcement of separate restroom facilities impossible because it “would require schools to assume gender identity based on appearances, social expectations, or explicit declarations of identity.” ...Accepting the Board’s position would equally require the school to assume “biological sex” based on “appearances, social expectations, or explicit declarations of [biological sex].” Certainly, no one is suggesting mandatory verification of the “correct” genitalia before admittance to a restroom. The Department’s vision of sex-segregated restrooms which takes account of gender identity presents no greater “impossibility of enforcement” problem than does the Board’s “biological gender” vision of sex-segregated restrooms.

